



Department of Human Resources  
311 West Saratoga Street  
Baltimore MD 21201

## ACTION TRANSMITTAL

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**TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES  
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT  
FAMILY INVESTMENT SUPERVISOR AND ELIGIBILITY STAFF  
HEALTH OFFICERS, LOCAL HEALTH DEPARTMENTS  
PROGRAM MANAGERS, LOCAL HEALTH DEPARTMENTS  
LOCAL HEALTH DEPARTMENT SUPERVISORS AND STAFF  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE OFFICE OF  
ELIGIBILITY SERVICES MANAGERS AND STAFF**

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**RE: MARYLAND HEALTH CONNECTION SPECIAL CIRCUMSTANCES  
PROCEDURES**

**PROGRAM AFFECTED: MEDICAL ASSISTANCE – MODIFIED ADJUSTED GROSS  
INCOME ELIGIBLES**

**ORIGINATING OFFICE: OFFICE OF ELIGIBILITY SERVICES**

### **BACKGROUND:**

The new on-line health benefit exchange (HBX) for the Maryland Health Connection (MHC) allows Marylanders to apply for Modified Adjusted Gross Income (MAGI) Medicaid and Qualified Health Plans (QHP). All applicants, who meet all other eligibility requirements for Medicaid, through the HBX will receive 90 days of temporary eligibility on a Fee-For-Service basis, even if they have outstanding verifications.

The Departments of Health and Mental Hygiene (DHMH), Human Resources (DHR), and the Maryland Health Benefit Exchange (MHBE) developed procedures to assist consumers with their on-line applications, and process changes reported by consumers.

MHBE developed the Special Circumstances Guide to provide explanations of how to:

1. Assist the consumer during the application process to submit a complete application,
2. Complete the verification process in the Worker Portal, and
3. When to escalate a case for special processing.

The Special Circumstances Guide is available on the Hub site, <https://stateofmaryland.csod.com/client/doi-maryland/default.aspx>, within the Learning Management System (LMS) and DHR's Knowledge Base. A copy is attached to this transmittal. Staff will receive job aids to supplement MHC procedural documents. Current MHC resources in addition to the Special Circumstances Guide include the:

- Consumer Portal User Guide
- Verification Caseworker User Guide
- Verification Administrator User Guide
- Workplace and FILENET Job Aids
- Identity Proofing Job Aid (attached)
- Income Verification Change Report (attached)

### **PROCEDURAL METHODS:**

Staff helping to file health care applications via the Consumer portal or the MHC Worker Portal will use the information below to complete the eligibility process. This transmittal outlines circumstances that impact:

1. Staff processing verifications in the Worker Portal,
2. Staff assisting with the application process for MAGI and QHP health care applications, and
3. Applications requiring processing via the Client Automated Resource and Eligibility System (CARES).

### **Application Processing Tip**

If you leave your computer while you are processing verification and are "timed-out" of the HBX, an error will occur. When you log back in to the HBX and complete the case, the case will not read over to Medicaid Management Information System (MMIS) as an open span. The workaround will require a Certification Turnaround Document (CTAD) to fix the coverage span. You must be careful to save your work and log-off properly to prevent issues with the HBX reading over to MMIS.

### **A. Processing Applications via the Consumer Portal**

1. All new applications for MAGI Medicaid must be completed in the consumer portal of the HBX. Staff should assist consumers with completing applications in the Consumer Portal.
2. All cases must be screened in MMIS to determine if current Medicaid eligibility exists.
3. If the consumer is applying for a Non-MAGI Medicaid program, complete the

application in CARES using the 9701.

4. Follow your Standard Operating Procedures to hand cases off to a Navigator for QHP Plan selection, if needed.
5. If the consumer has active coverage through the Health Insurance Exchange (HIX), process as a new application in the HBX for an MAGI Medicaid or QHP subsidy eligibility determination.

## **B. Processing Applications via the Worker Portal**

1. Expediting Pregnant Women through the Verification Process
  - a. Verifications for pregnant women must be expedited to allow the consumer to select a Managed Care Organization (MCO).
  - b. When a pregnant woman files an application, the case manager must request the Verification Administrator (VA) to re-assign the verification task to update the application.
  - c. The VA can pull the verification task from the State pool and reassign.
  - d. LHD staff must review and process reports to ensure pregnant woman approved for the 90 day temporary eligibility have their verifications expedited and receive MCO coverage. These applications must be processed using the 2-10 day standard for pregnant woman (Reference ACE Manual).
2. Withdraw/Dis-enroll
  - a. Medicaid applicants or recipients can withdraw their application at any time. (Reference COMAR 10.09.24.04 G)
  - b. If a consumer wishes to withdraw from a QHP, and is currently enrolled in coverage, they must withdraw during the open enrollment period or have a special circumstance reason to dis-enroll.
  - c. To dis-enroll the consumer, a VA:
    - Selects the appropriate Application ID
    - Selects "Report a change"
    - Clicks on "Do not want coverage"
    - Adds case comments pertaining to the reason for the request, and
    - Reruns eligibility.
3. Death of a Primary Applicant

Death of a primary applicant requires the eligibility to be re-determined for all remaining household members. The VA selects the Application ID:

  - a. Selects "Report a change"
  - b. On the "Applicant and Family-Household Members" screen, indicates that

- all household members are not applying for coverage
- c. Clicks “Submit Changes”
  - d. Views eligibility determination to confirm that all household members are **ineligible** for all programs
  - e. Re-enrolls remaining household members by creating a **new** application in the Worker Portal
  - f. Assigns a **new** primary applicant
  - g. On “Special Enrollment Questions”, indicates “**Loss of Minimum Essential Coverage**” (MEC) and date of death for the previous primary applicant
  - h. Adds case comments: “The primary applicant died on (enter **date of death**). The entire family was dis-enrolled from coverage on (enter **disenrollment** date). The family will be/was re-enrolled on a new application”.

**NOTE: It is important to refer to the Special Circumstances Guide at the time of this change. The process may be changed during the development of the HBX.**

- 4. Consumers eligible for Emergency Medicaid
  - a. Consumers who are not eligible for Medicaid due to their unlawful immigrant status may be eligible for coverage of emergency medical services.
  - b. Applications for Emergency Medical Services must be processed in CARES **only**, using the 9701.
  - c. Procedures for processing X02 applications remain unchanged (Reference AT12-11 Revised).
  - d. The S98 workaround will still need to be completed for the new adult category, A02 (New childless adult enrollees, 0-138% FPL).

### **C. Processing Changes**

- 1. A change in circumstances may result in the consumer:
  - a. Remaining eligible for Medicaid;
  - b. Moving between Medicaid and QHP eligibility; or
  - c. Being eligible for a Special Enrollment Period (SEP).
- 2. Procedures for Making Changes
  - a. All cases must be screened in MMIS, to determine if current Medicaid eligibility exists.
  - b. If the consumer has active coverage through the HIX, process the reported

change as a new application in the HBX for MAGI Medicaid or QHP Subsidy Eligibility.

- c. If the consumer is not currently active in MMIS, but has an eligibility determination from the HIX; complete a CTAD to record the eligibility span on MMIS.
  - d. Once the CTAD has been completed and the eligibility span is showing on MMIS, process a new application on HBX to record the change.
  - e. If a consumer is showing an active span on MMIS but has no corresponding case on CARES or HIX, take the information found on MMIS and process the application on CARES from the original application date.
  - f. If the consumer is currently applying for Medicaid and attest to information that triggers a Verification Check List (VCL); and the consumer or electronic sources reveal conflicting information:
    - Update the information on HBX as “Report a Change”
    - On the Signature line choose “YES” and “e-signature”
    - Add the following free form text to the case comment section:

“The signature field was updated by [Your Name] based on the verification document provided by [**consumer, MABS, SVES, etc.**].”
  - g. If the consumer is active on the PAC system as an A01, the Eligibility Determinations Division (EDD) will process the new application in the HBX.
  - h. If a case is active on CARES and the consumer reports a change, process the change on CARES through 2/15/15. Effective 2/16/15, if a consumer that is active on CARES reports a change, process the change as a new application in HBX using the date the change was reported as the date of application.
3. Income Verification Change Report
- a. When a consumer reports or sends in a verification document, with income not matching the attested income reported on the Maryland Health Connection application, that income must be updated with the income provided on the document.
  - b. The income is updated by reporting a change (see Verification Worker Quick Reference Guide job aid attached).
4. False Incarceration Determination
- a. Consumers are being denied health coverage due to the federal hub pulling information indicating the customer is incarcerated.
  - b. MHBE is aware of this issue and is developing a process to redetermine eligibility for these consumers. Pending further instructions, any consumer

that states they have been incorrectly denied can provide one of the following forms of documentation:

- A signed affidavit (see attached)
  - A copy of release papers from the institution
  - A document showing active employment or evidence that they lived in the community in the last 60 days
- c. The local departments of social services LDSS and local health departments (LHD) staff can upload this information to FILENET
- d. LDSS staff will send an e-mail to the dedicated e-mail account, [fia.rrt@maryland.gov](mailto:fia.rrt@maryland.gov).
- Include the consumer's name and Application ID number

**Remember**, any document containing personal identifying information must be **encrypted** prior to forwarding to the RRT.

5. Consumer Assistance

- a. Consumers calling to report an issue completing an application, or a change can be directed to the MHC Call Service Center (CSC) at 855-642-8572 (TTY 855-642-8573), the LDSS or LHD.
- b. If you receive an inquiry you should attempt to assist the customer until you reach a point where you must hand-off to another entity or Help Group (Tier II, Super User, etc).

**INQUIRIES:** For questions about MA policy, please contact the DHMH Division of Eligibility Policy and MCHP at [\(410\) 767-1463](tel:4107671463) or [1-800-492-5231](tel:18004925231), (select option 2 and request extension 1463). LDSS staff should contact the Office of Health Care Initiatives Rapid Response Team with questions on MHC application processing at [fia.rrt@maryland.gov](mailto:fia.rrt@maryland.gov) or (410) 767-1727.

cc: DHR Executive Staff  
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